

## INSTRUCTIONS

### COMPLETING THE OPC LME AUTHORIZATION REQUEST FORM (ARF)

Please note: To ensure timely processing of your Authorization Request Form, please complete all sections prior to submission to OPC. Type or print legibly. Check/circle responses where applicable. Use the ARF for printing out and completing the form by hand. Use the eARF (recommended) if you want to complete the template on your computer. For the eARF, navigate the form using only your mouse, Tab, or arrows. Do not use the 'spacebar' or 'Enter'.

#### Client Demographics:

Information requested	How to complete this section
Medical Record #	This is the number assigned by OPC upon enrollment of client
Medicaid ID#	Complete when client has Medicaid. This is the ID# from the client's Medicaid card.
County of Residence	County in which adult consumer resides. If under 18, county of legal guardian's residence.

#### Financial Information:

Information requested	How to complete this section
Insurance status and efforts to seek entitlements	Insurance status and results of application for entitlements is required. If no application for benefits, explain reason.

#### Current Risk Assessment:

Information requested	How to complete this section
Client's risk to self:	Indicate client's level of, or absence of, suicidality by circling the appropriate value. <b>This must be completed</b>
Client's risk to others:	Indicate potential for, or absence of, violence and/or abuse by circling the appropriate value. <b>This must be completed.</b>

#### Current Impairments: (Please select/circle one value for each type of impairment. This must be completed.)

Rating	Definition
0 = none	No evidence of impairment
1 = mild	Occasional impairment or difficulties, but no interference with normal daily activities
2 = moderate	Currently experiencing difficulties, frequent disruption in daily activities, requires periodic or continuous assistance with some tasks
3 = severe	Currently experiencing severe symptoms, potential risk of harm to self/others, severe distress and/or disruption in daily activities
4 = not assessed	Impairment was not assessed. <b>Please note use of "na" may result in additional faxes or phone calls with OPC to ascertain this information.</b>

#### ASAM Dimensions:

Information requested	How to complete this section
Intoxicated/Withdrawal Potential	<ul style="list-style-type: none"> <li>Low – Not under the influence, no withdrawal potential</li> <li>Medium – Recent use, ; moderate withdrawal potential requiring 24 hour monitoring</li> <li>High – Severe withdrawal history, presenting with severe withdrawal; history or current seizure activity</li> </ul>
Biomedical Conditions	<ul style="list-style-type: none"> <li>Low – No current medical problems or complications</li> <li>Medium – Diagnosed medical condition requiring monitoring but not intensive treatment.</li> <li>High- History of, or identified medical condition that requires 24 hour medical/nursing monitoring and/or intensive treatment.</li> </ul>
Emotional/Behavioral/Cognitive Conditions	<ul style="list-style-type: none"> <li>Low- No current cognitive/emotional/behavioral conditions</li> <li>Medium – Impaired mental status; passive suicidal/homicidal ideations; impaired ability to complete ADL's</li> <li>High – Active suicidal/homicidal ideation; acutely psychotic/delusional/labile; impacting ability to engage in treatment; symptoms require 24 hour psychiatric care.</li> </ul>
Readiness to Change	<ul style="list-style-type: none"> <li>Low – Ready for/accepting need for treatment; attending, participating, and can ID future goals, plans</li> <li>Medium – Ambivalent about treatment; seeking help to appease others; avoiding consequences; variable to poor engagement</li> <li>High – lacks awareness of need for treatment despite severe consequences; refusing or is unable to engage; mandated for treatment by workplace, DSS and/or court system.</li> </ul>
Relapse Potential	<ul style="list-style-type: none"> <li>Low – Recognizes onset signs; uses coping skills with CD or psychiatric problems</li> <li>Medium – Awareness of relapse triggers or onset signs for MH/SA issues but requires close monitoring</li> <li>High – Continues to use; unable to recognize potential signs and triggers for MH/SA issues despite consequences: unable to control use without 24 hour structured setting.</li> </ul>
Recovery Environment	<ul style="list-style-type: none"> <li>Low – Supportive recovery environment for MH/SA issues</li> <li>Medium – Moderately supportive environment/resources for MH/SA issues</li> <li>High – Environment does not support recovery behaviors or efforts; resides with active substance users or abusive individuals; coping skills and recovery requires a 24 hour structured setting.</li> </ul>

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**Treatment History - Must be completed when seeking Enhanced Benefits or Re-Authorization of any service (It is often helpful in initial ARFs also.)**

Information requested	How to complete this section
Psychiatric Treatment in Past 12 Months	This may include client's current course of outpatient treatment
Substance Abuse Treatment in Past 12 Months	This may include client's current course of outpatient treatment
Treatment Compliance (Non-Medication)	This is compliance with behavioral health treatment, not medication compliance
Services currently and/or recently received	Any recent service client had received. Include all services paid by client or a 3 <sup>rd</sup> party including Medicaid
Current Psychotropic Medications	List the client's primary medications and whether or not the client is usually adherent. If more space is needed please list of a separate sheet of paper.

#### Provider Demographics

Information requested	How to complete this section
Name of Requestor	Name of person completing the form. Should be clinician from consumer's "Clinical Home"
Provider/Agency	Name of agency identified as consumer's "Clinical Home"
Phone & Fax	Phone & Fax #s of agency identified as consumer's "Clinical Home"

#### Client Information

Information requested	How to complete this section
Diagnosis	All five Axes required. List Primary; add Secondary as appropriate. For Axis I and II the diagnoses must be both coded and written out. For all Axes indicate if there is no diagnosis (or no stressors on Axis IV) – don't just leave blank. Please see DSM IV-TR for further instructions. Requestors should collaborate with clinician from client's "clinical home" for consistency of diagnoses.
Level of Care	Required. See "OPC Level of Care (LOC) Criteria"
Target Populations	Required for consumer enrollment. List <u>all</u> target populations for which the client is eligible. Requestors should collaborate with clinician from client's "clinical home" for consistency of Target Populations. See also <a href="http://www.dhhs.state.nc.us/mhddsas/iprsmenu/index.htm">www.dhhs.state.nc.us/mhddsas/iprsmenu/index.htm</a>
Are the client's family/supports involved with treatment?	This must be completed.
Coordination of care with other behavioral health providers?	This must be completed.
Coordination of care with medical providers?	This must be completed.
Has client been evaluated by a psychiatrist?	This must be completed.

#### Service Authorization Request

Information requested	How to complete this section
Requested Start Date for this authorization	Date must be at least 5 working days ahead of the date of submission of request
Provider Agency	Name of <u>contract agency</u> (and specific program or site if the agency operates multiple programs or has multiple sites), e.g. ' <i>Alpha Foundation- Club Galaxy</i> ' or ' <i>Alpha Foundation- AF Group Home</i> ' or ' <i>ABC Services- Pittsboro</i> ' or ' <i>ABC Services- Roxboro</i> '. Specific information is needed to have the authorization credited and reported to the provider of the service. <b>OR</b> OPC contracted clinician providing IPRS service for which authorization is requested.
Service and Code	Use Name of Service and Code in Service Array of '05-'06 (updated 3/30/06) on IPRS website
Service Unit	How service is counted (e.g., by <u>Event</u> , or by <u>15-minute</u> units, or <u>Per Diem</u> , etc.)
# Units / Day, Wks, Mo.	This is the service frequency or <u>Number of Service Units per Time Interval</u> e.g.: '2 / mo.' – means 2 <u>units</u> a month; '1 / 3 mo.' – means one <u>unit</u> every three months. And, for example, for a service that is counted in 15-min. units -- if you want 2 hours every 3 weeks, then the request is '8 / 3 wks'. Or if a service has a service unit of an 'event', then a request of <u>one event</u> every 2 weeks would be '1 / 2 wks'. For a one-time service enter a frequency of "once".
Additional Comments	Add any additional clinical info supporting the request or comments clarifying the request, etc.
Signature of Requestor & Date	Signature of person completing form. Date form was completed and faxed to OPC.
Signature of LME Authorizer & Date	For LME use only